DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/10/2012 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING C B. WING 08G001 01/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 26351 PATRIOTS WAY STOCKLEY CENTER GEORGETOWN, DE 19947 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 000 **INITIAL COMMENTS** W 000 W 108 An unannounced annual survey and complaint Direction was placed in the staff's visit was conducted at this facility from January 23, 2012 through January 27, 2012. The daily communication book regarding deficiencies contained in this report are based on the kitchen cabinet containing observation, interviews, review of clients' records and review of other facility documentation as chemicals being kept locked for safety. indicated. The facility census the first day of the The additional task of checking the survey was sixty-six (66). The survey sample cabinet was added to the staff's written totaled thirteen (13) clients. W 108 483.410(b) COMPLIANCE W FEDERAL, STATE W 108 assignments. Exhibit A & LOCAL LAWS Completed 2/1/12 The facility must be in compliance with all The topic of chemical safety and the applicable provisions of Federal, State and local keep locked requirement was reviewed laws, regulations and codes pertaining to safety. in the 102WW staff meeting on 2/13/2012, and the Residential Nursing This STANDARD is not met as evidenced by: Management meeting on 2/6/2012. Based on observation in the kitchen of 102 Completed 2/6/12 & 2/13/12 Waples Way, it was determined that the facility failed to ensure the safety of the residents living The facility's chemical storage in the cottage by leaving chemicals unlocked. practices were reviewed and checked Findings include: for compliance. All chemicals are not On 1/25/12 at 9:45 AM, the right side cabinet door located under the sink was unlocked. accessible to residents and/or locked. Several bottles of cleaning supplies were located Completed 2/16/12 in this cabinet and a sticker posted on the front of the door read, "keep locked". The doors to the The addition of child safety locks on kitchen were open and the room was accessible the kitchen cabinet to further deter to ambulatory clients. W-331 483.460(c) NURSING SERVICES W 331 access by residents. To be completed by 2/28/12 The facility must provide clients with nursing services in accordance with their needs.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| This STA Based of facility's defermin out of 13 provide of accordant thorough continuo when he failed to addition, with num needs assessm failed to had a ch blood pro blood ox notify the facility fa C12's co admitted respirate pneumon 1. C111 mental in severe of gastrost progress receiving morphin C11 had C11's no documen | in record revipolicies and led that for it is sampled clicients with more with their ly assess Crus oxygen the experienced promptly not the facility faing services The facility faing services The facility faing in concessure, rapid ygen saturate medical tearled to close Indition which to the hospid ry failure second in the company failure second in the company tube/G-tailure pulmonal oxygen at 2 etherapy for a current "Ersing care plat signs and | not met as evidenced by: iew, interview, and review of procedures it was iree (C11, C13, and C12) ents, the facility failed to ursing services in needs. The facility failed to it's (was dependent on erapy) respiratory status a change in condition and ify the medical team. In iiled to respond promptly in accordance with C11's iled to do a thorough respiratory status and ify the medical team. C12 iition as evidenced by low heart rate, and decreasing ion and the facility failed to m promptly. In addition, the y monitor and reassess in resulted in C12 being tal for acute hypoxemic condary to aspiration | W3 | W 108 continued Supervisors will extra checks on sincluding 102 Wydocument their from corrections. Complete The Office of Quivill complete quinspections. To be completed by the completed with a the referenced incompleting staff outly for completing the supervisors. | be instructed to make safe chemical storage W kitchen, and to indings and Exhibit B ed 2/17/12 & Ongoing sality Management arterly environmental by 4/14/12 & Ongoing ective actions were all nurses involved in cidents. Completed 2/17/12 at on 2/6/12, to all ining the expectations acrough physical prompt notification of |

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| W 331 | flaring, apnea etc. Review of C11's rotattending physician blood pressure (B/F 88 per minute, resp pulse oximetry (mor 92% on 2 liter of ox The CNA (certified 14/16/11 and timed 4 "yelled more today approximately 8:15 documented C11's 100.8 F axillary, RR 95-98% on 2 liters noted) and a respirarion of the commented was "S Respiratory (therapi seconds." The nurs notified and orders order read as follow 1. Tylenol (medica (milligram) via G-Tu 2AM, 12 noon, 4PM x (times) 48 hrs. (hor 2. Vital signs q (eve 3. Sputum culture 4. CXR (chest X-ray 5. Avelox (medicatic G-Tube q day x 10 cobtained." There was no signa physician or the NP. | offine progress note by the dated 4/11/11 documented by of 107/72, heart rate (HR) of iratory rate (RR) of 18, and nitors oxygen saturation) of ygen. The progress of the pro | W . | 33.1 | W 331 continued A sweep of records for recent significant med completed using the a Nursing/Medical Revious | tical issue ttached Control is the wind is a review tor of Nuctive action in staff will be proposed by the control in the wind in the wind in the control in | s was OR 2/21/12 s will be rsing ons will 3/3/9/12 on esented eeks of 3/16/12 ocedure utine |
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| W 331 | pulse oximeter 95% RR 30, and BIP 106 seconds and gruntil documented. The n record for April 201 medication, APAP of Tylenol) was admin that shift and the nuthe charge nurse no was on call. The nig 4/17/11 documented AM. The RR was 22 documentation of C oxygen level) other reading of 93% and nurse documented amount and superviolation of C oxygen level of 28, while C11 was lung (some rhonchi, gastrointestinal (abd distention) assessm culture, CXR and Accompleted (no respiration of the nursing note at C11 was found at a grunting at a rate of oximetry 81% (critic oxygen which only increased to 4 liters with HR of 115 and therapy was notified to auscultate breath liters was applied will record of the record of | on 2 liters oxygen, HR 122, 5/73. A seizure lasting 15 ng respirations were also redication administration 1 noted C11's routine bedtime 550 mg. (which was a form of istered. C11 had not voided rise reported these findings to be the Nurse Practitioner who the shift nursing note dated divital signs from 12 AM to 5 et o 28 but there was no 11's respiratory status (or than the pulse oximetry HR of 122 at 12 AM. The that C11 voided a small sor was notified. | W-331 | The Physician's Gene Orders and Medical Topolicy for medical teat will be revised to incle for when a member of team does not respond To be confered in the nurse supervisors on proper completion. Nursing/Medical audit To be comfered in the nurse supervisors routine periodic COR Medical audits to ensure documentation and prof the medical team in To be completed by 4. These audits will be redirector of Nursing for practices and approprise taken with the nurse To be completed by 4. Designation has been nursing educator at St. | ceam Notification am notification ude instructions of the medical difference of the medical difference of the COR at the medical of the COR at the medical difference of the COR at the medical of the medical of the COR at the medical of the medical of the COR at the medical of the COR at the medical of the COR at the medical of the medical |

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| W 331 | Continued From page 4 policy). The nursing supervisor was notified and C11 was transported to the (name of hospital) where he was admitted for treatment. The treatment was discontinued and C11 was given IV Morphine and later expired at 7:30 PM. Cause of death documented as acute respiratory failure and pneumonia. The facility's medical procedure titled "Physician's Generic Standing Orders and Medical Team Notification" included "III Procedure, 3. The medical team should be notified promptly by phone or in person if; a. a resident is placed on oxygen, the oxygen level is increased, or the resident develops respiratory distress. Be sure to obtain a full set of vital signs, auscultate lungs, and have the respiratory treatment plan available prior to call. c. a resident develops increased pain, fever over 100 degrees orally or equivalent, or other abnormal vital sign such as high or low blood pressure or respiratory rate appears clinically significant." Review of the facility's nursing policy and procedure titled "Nursing Documentation" stated: "IV. Situation Requiring Documentation." Change in individual's health status (illness or injury) -Observations on each shift during an illness, including vital signs and pain scale as indicated until symptoms are resolved Documentation should continue on an illness for the duration and should include medications, their effectiveness, any side effects and notification of the physician." | W 331 | • The Executive Director established a more the death review process. **Completed 2/1* • The Office of Quality will be asked by the Experience of Director to complete simplementation of any recommendations/chameasures for all death After the Next Director to the "Fixed Review Committee" to responsibility to ensurindividual records with regulatory statutes and licensing standards ac | rough internal Exhibit E 6/12 & Ongoing Management xecutive surveys to ensure riggs/corrective s. reath & Ongoing Committee has acility Peer hat will have the re compliance of h applicable l accrediting/ ross all settings. Exhibit F 6/12 & Ongoing Management xecutive quarterly random lementation of / changes/ or all deaths. |
| | Although C11 was correctly transported to an acute care hospital for change in health condition, | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| | the medical team (ras the elevated HR PM and 12 midnigh an 8 hr. shift on a ferspiratory assessme following AM on a crespiratory complicates documented si and did not notify the was in acute respiratory. The radiology servic CXR after-hours and the sputum cultures ordered for the AM. An interview with refl/26/12 at approxim the therapists worken urses are to perform the therapists worken in their at on nasal cannula oxexception per facility abnormal findings to statements were companied to the companied of the companied that interview with the 1/27/12 at approxim delay in service of CXR and sputum or until the AM, thus, a | ge 5 report significant changes to nurse practitioner on call) such and RR on 4/16/11 at 9:55 t and no urine output during shifle client. There was no ment from 8:15 PM to 6:30 the lient who was having ations. The nurse on 4/17/11 gnificant changes at 7:17 AM e medical team until the client story distress at 10:55 AM. The was available to perform distress could have obtained yet diagnostic services were spiratory therapist, E9 on lately 2:30 PM revealed that ad 10-12 hrs. daily and the mail respiratory care and sence. (They also document yen dependent clients by policy and report any of the nurse on duty.) These infirmed by the Qualified Professional (E10) at 2:45 e medical director E6 on ately 11:30 AM confirmed the lagnostic services including liture which were not done noticities were not signed and | W 331 | н | | | |
| | nursing assessment | s were not complete. wed with Director of Nursing, PM who also confirmed the | * | | | | |

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| W 331 | Continued From page 6 | W. 3 | 331 | ri | × | |
| | above findings | | | ' | | |
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| | | 1 1 | * | | - |] |
| | 2. C13 was admitted to the facility with diagnoses | * a * | | | | 1 |
| , | that included profound mental retardation, | | | | 1 | |
| • | hypothyroidism, osteoporosis, severe | | | | | |
| : | kyphoscoliosis, thrombocytopenia, bipolar | | | | |] |
| | disease, blindness, dysphagia, colostomy and | | | | • | |
| | jejunostomy tube. | | | * * | | |
| | | - | | | | |
| | The November 2011 physician order for C13 | | | | | J |
| | documented an order for "Duoneb 2,5/0,5 mg, via | | | • | | |
| | nebulizer every 4 hours as needed for shortness | , | | , | | |
| w . | of breath/wheezing." | | | | | |
| | | | | | | |
| | Review of C13's "Interdisciplinary/Progress Notes | ٠, | | | | |
| | (IDCP Notes)" dated 11/27/11 and timed 6 AM | | k, | | | |
| | written by the 11-7 CNA stated C13 was awake | *: | | | | |
| | on and off through the night with some coughing. | | | <u> </u> - | · | |
| | The 11-7 nurse documented in the IDCP Notes that at 6 AM, C13's vital signs were T of 97.6 F | < | | - | 1 | |
| | axillary, B/P 118/68, HR 88, RR 20 and her pulse | | | | | |
| | oximetry of 95% on room air. The nurse | 3 | ٠. | A transfer of the second | ŀ | |
| | continued to document that C13 had a deep, | | | | | |
| | non-productive cough that was noted throughout | | |] | | |
| 1 | the night. | • | | | | |
| | | | | | | |
| | The facility's nursing procedure for "Assessing | ٠. | . | | | |
| | Respirations" stated to determine the rate and | ٠ , . | | | | |
| 1 | quality of a resident's respiration rate the nurse | 44 y | | - | } | |
| | assess the depth of the respirations by observing ! | | ٠, | | | • |
| | movement of the chest. Describe as normal. | | | | | * |
| , - | deep or shallow. The nurse should auscultate | | i | | ļ | |
| | and percussion may be needed to assess | - | | | 1 | |
| i | abnormal lung sounds. Document and report | | | -1 | | |
| . } | pertinent assessment data; C13's record lacked | | 41 | | | |
| | evidence that her lungs were auscultated or an | | | | | |
| | assessment was done of the depth of her | | | 1 | i | |
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| STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BU | ILDIN | | (X3) DATE | (X3) DATE SURVEY COMPLETED C | |
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| Which Lat | Pipe | | | <u> </u> | SEORGETOWN, DE 19947 | · · · · · | |
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| | respirations even the have deep non-pro- evidence that the re- | nough she was documented to ductive cough. There was no aspiratory staff were notified assessment and care. | VV · a | . , | | , u | |
| | documented that shall also shall | 30 AM, the 7-3 nurse he walked into C13's room at a sitting in her wheelchair. touch, mouth cyanotic. There are supervisor was notified and ed dead. The nursing need that the physician and the led. The record review lacked that the 7-3 nurse assessed nge in condition by having a e cough on the 11-7 shift and deceased. | 5 | | | | |
| | Medical Team Notifi medical team prom | c Standing Orders and ication" revealed to notify the ptly by phone or in person if sident has a change in level of ation, etc" | c | | | | |
| | AM from E8, previo "Patient was found wheelchair at 11:24 with vital signs at 6 non-productive cou- not reported to me." | AM. She had been afebrile AM, but had a deep gh noted through the night but An autopsy was requested. | 9 | | | | |
| | cause of death was death, tracheobrone debilitating condition medical conditions, | ath certificate revealed the sudden cardiorespiratory chial plugging of mucus, n, old age and multiple and dysphagia. The manner nented as being natural. | | | | | \ \ |

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| W 331 | Continued From page 8. | w: | 331 | - " | | | |
| ٨ | On 1/26/12 at 12:05 PM, an interview with E3, Director of Nursing revealed that the 11-7 nurse | , , | | i i | | , | |
| | should have completed a thorough assessment. The physician should have been notified and this change of status should have been documented | | | , | • | | |
| | on the Situation Background and Assessment Recommendation and the 24 hour report. | | | , | • | | |
| v | Review of these reports with E3 failed to have documentation concerning C13's change in | , | , | .], | | | |
| | health status. The 7-3 nurse should have assessed C13 when she came in and should have contacted the physician when the 11-7 | | | | | | |
| | nurse failed to do so. The staff could have notified the Respiratory staff if they had a respiratory/coughing concern. | | | | | | |
| | On 1/27/12 at 8:50 AM, the surveyor met with the Administrator E1, the Medical Director E6, and E3. The concerns surrounding the care of C13 | š. | | *** | | | |
| | identified were presented to this team. All the concerns were confirmed. | · . ·, | | | | | |
| | On 1/27/12 at 11:10 AM interview with E7, Respiratory Therapist revealed that if anyone | , | y | | | | |
| | from his department was notified of any respiratory problem or coughing problem; they | , | | | | | |
| | would have documented their assessment in the IDCP Notes or on the Treatment Assessment Record. Review of these two records failed to | à | .3 | | • | | |
| | have documentation that the respiratory personnel were notified of C13's non-productive. | | ĸ | | | | |
| | deep cough or that a staff member administered a nebulizer treatment for C13. | | | | | | |
| | 3. C12 was admitted to the facility with diagnoses including mental retardation severe, Tourette's Syndrome, osteoarthritis, hypertension, histories | a | | | | | |

| STATEMENT AND PLAN C | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: | (X2) MUL A, BUILDI | TIPLE CONSTRUCTION NG | (X3) DATE S COMPLE | TED |
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| W-331 | Continued From pa of anemia and iron constipation. | | W-33 | | | |
| | Review" dated 2/20 | ursing Quarterly Visual /11 documented B/P 121/80, pulse oximetry of 96% on | | | • | |
| | titled "Physician's C Medical Team Notif medical team prom "Procedure, 3, c, a pain, fever over 100 or other abnormal.v | lty's policy and procedure Seneric Standing Orders and loation" revealed to notify the otly by phone or in person if resident develops increased degrees orally or equivalent, ital signs such as high or low applicatory rate which appears | | | | |
| | 7:24 AM documente that C12 was compl signs included B/P of and pulse eximetry vomited small amou emesis and abdomi hypoactive bowel so | Notes" dated 3/15/12 timed by E4 (Registered Nurse) aining of nausea and vital of 86/64, HR of 102, RR of 24 of 90-92%. In addition, C12 int of frothy white/clear nal assessment revealed bunds with tendemess noted lower quadrant and to be | | | | |
| The state of the s | the findings on the f Communication Wo communication to re team that are non u Although C12 had a evidenced by low bi | ove assessment documented acility's "Resident Care rksheet" (a written form of elay information to the medical rgent). abnormal vital signs, as ood pressure, rapid heart g oxygen saturation, record | ÷ | | • | |

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| | 2 4.5 | | | | | |
| W 331 | Continued From page 10 | , W3 | 31 | The same | | |
| | review lacked evidence that the medical team was promptly notified. | | | | | |
| a. | Subsequent IDCP Note dated 3/15 and timed 9 AM documented that NP (Nurse Practitioner/E5) called unit and E5 notified of C12's status. | | | | | |
| | Emesis X2 | | .] | · · · · · · · · · · · · · · · · · · · | | |
| | Subsequent IDCP Note dated 3/15 and timed 12:20 PM documented that at 10:40 AM, C12's HR was 120, RR24, pulse oximetry of 84-88%. Oxygen tank obtained with nasal cannula. Resp. (Respiratory) and NP (E5) contacted. Lungs bilaterally with rhond, color poor, and using accessory muscles. Respiratory distress. Code called. C12 sent by ambulance to the hospital. | | | | | 111111111111111111111111111111111111111 |
| | Record review lacked evidence that C12's health condition was closely monitored or reassessed from the initial assessment at 7:24 AM till 10:40 AM, when C12 was found in respiratory distress. | | | | | |
| | Review of the admission history and physical dated 3/15/11 revealed that upon arrival, C12's B/P was 77/53, HR of 124, RR of 59, and pulse oximetry was between 78-80%. "Reason for Admission: acute hypoxemic respiratory failure secondary to aspiration." | | | | •. • | |
| To the second se | An interview with E4 (Registered Nurse) on 1/26/12 at approximately 10 AM revealed that she had E5 paged through the facility operator three times before E5 contacted the unit at 9 AM. E4 further related that she checked on C12's after the initial assessment at 7:24 AM, however, E4 could not recall what reassessment information was gathered. | | The state of the s | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | FOR MEDICARE F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 7 | JIĽDIN | PLE CONSTRUCTION | XI. | | JRVEY . |
|--------------------------|---|--|-----------------|----------|---|---|-----------|----------------------------|
| | OVIDER OR SUPPLIER | | * | 2 | EET ADDRESS, CIT 6351 PATRIOTS W EORGETOWN, E | ΑY | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | IC PRE TA |) FIX | PROVIDE (EACH COR) | R'S PLAN OF CORR RECTIVE ACTION S RENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | 2:35 PM revealed to she was paged through the was paged through the was paged through the light to the client to the would have known quickly deterioratin. An interview with Ed PM confirmed the health condition, it is should have been. | 5 on 1/30/12 at approximatel hat she does not recall that se times on 3/15/11 from AM to 9 AM. In addition, E5 was informed of the above in condition, E5 would have a hospital earlier since she that the client's condition was g. 3 on 1/27/12 at approximatel at due to C12's change in e staff on the medical team contacted immediately. In | y s y | 331 | | | | |
| | that C12's health o closely monitored | I that she would have expect ondition would have been and reassessed. with E1, E2 (Director of | ed | | | ı | · · · · . | |
| - | Residential Service approximately 1:30 | es), and E3 on 1/27/12 at | | | • | | | |
| | | | | ± | | | | |
| | | | | • | | | | |



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| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED |
|------------|---|--|
| | 1. | DATES TO BE CORRECTED |
| | 97. 176 | |
| | An unannounced annual survey and | |
| • | complaint visit was conducted at this | |
| | facility from January 23, 2012 through | |
| | January 27, 2012. The deficiencies | |
| | contained in this report are based on | |
| | observation, interviews, review of clients' | |
| | records and review of other facility | |
| | documentation as indicated. The facility | |
| | census the first day of the survey was | |
| • | sixty-six (66). The survey sample totaled | |
| | thirteen (13) clients. | |
| * • | | |
| 3201 | Skilled and Intermediate Care Nursing | |
| • | Facilities | * |
| V | | F |
| 3201.1 | Scope | Control of the second of the s |
| | | |
| 3201.2 | Nursing facilities shall be subject to all | |
| | applicable local, state and federal code | |
| | requirements. The provisions of 42 CFR | |
| • | Ch. IV Part 483, Subpart B, | |
| | requirements for Long Term Care | |
| | Facilities, and any amendments or | ÷ |
| | modifications thereto, are hereby | |
| • | adopted as the regulatory requirements | |
| | for skilled and intermediate care | |
| | nursing facilities in Delaware. Subpart | , |
| | B of Part 483 is hereby referred to, and | |
| | made part of this Regulation, as if fully | |
| e. | set out herein. All applicable code | * |
| | requirements of the State Fire | |
| | Prevention Commission are hereby | |
| | adopted and incorporated by reference. | |
| | | h. |
| 3201.6.0 | Services to Residents | |
| 0004.0.0.4 | A 12 | |
| 3201.6.2.4 | All written or verbal physician orders | * |
| | shall be signed by the attending | |
| | physician or prescriber within 10 days. | |
| | This was during a state of the state | |
| | This requirement is not met as | |
| | evidenced by: | |
| | Bood on spoord review and intended | |
| | Based on record review and interview it | |



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was determined that the facility failed to have verbal orders signed by the nurse practitioner for one (C11) out of 13 sampled clients. Findings include:

Cross refer Title 16, Chapter 11, §1131(9), Neglect a. Example 1

On 4/16/11 at approximately 8:15 PM, the charge nurse documented C11's vital signs: temperature (T) 100.8 F axillary, RR 36, HR 128, pulse oximetry 95 -98% on 2 liters oxygen (no blood pressure/BP noted) and a respiratory assessment as follows: "Rhonchi bilaterally. Grunting breathing." Also documented was "Seizure activity witnessed by Respiratory (therapist) lasting 1 minute & 15 seconds." The nurse practitioner (NP) was notified and orders obtained. The verbal order read as follows: "1 Tylenal (medication) 6.5 ml.

- " 1. Tylenol (medication) 6.5 ml. (milliliter)/650 mg. (milligram) via G-Tube pm (as needed) @ (at) 2AM, 12 noon, 4PM for temp. >99.9 Ax (axillary) x (times) 48 hrs. (hours)
- 2. Vital signs q (every) 4 hrs x 48 hrs.
- 3. Sputum culture 4/17/11 AM
- 4. CXR (chest X-ray) 4/17/11
- 5. Avelox (medication) 400 mg (milligrams) via G-Tube q day x 10 days after sputum culture obtained."

This order was not signed by the nurse practitioner or the physician.

Findings were reviewed with Director of Nursing, E3 on 1/27/12 at 12 PM who confirmed that the facility failed to ensure that the nurse practitioner signed C11's verbal orders.

3201.6.6.1

The facility shall maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.

3201.6.2.4

- The order has been signed by a physician.

 Completed 2/16/12
- Records were reviewed to ensure all medical team verbal orders have been signed. A note was left in the SBAR medical communication book for any orders that needed a signature.

Completed 2/16/12

 All verbal orders were signed by a member of the medical team.

Completed 2/17/12

• The nursing procedure for Noting a Physician's Order was revised 12/13/11. When the nurses are completing the 24 hours chart checks and discover an unsigned verbal order they are to leave a note for the medical team in the SBAR medical communication book that a signature is needed. (The unsigned order noted in the review was dated 4/16/11.)

Completed 12/13/11

• An email was sent on 2/15/12 to the medical team advising them to ensure all orders are signed when they are completing their 60-day reviews.

Exhibit A Completed 2/15/12 & Ongoing



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This requirement is not met as evidenced by:

Based on observations made in the All Star recreation building, it was determined that the facility failed to provide a clean environment for the clients. Findings include:

- 1. On 01/27/12 at 10:16AM, room #124 was being used by five residents and five staff members. The floor of this room was dirty and needed to be swept. The floor had a couple small circular, red, dried spills that needed to be mopped.
- 2. On 01/27/12 at 10:30AM, room #122 was being used by nine residents and four staff members. The floor of this room was dirty and needed to be swept.
- The hallway between the classrooms and the auditorium, where three linen carts were stored, needed to be swept as dirt and debris had accumulated under the carts.

3201.7.3.2

Heating, Ventilation, Air Conditioning. The HVAC system for all areas used by residents shall be safe and easily controlled.

This requirement is not met as evidenced by:

Based on observations made in the resident rooms on 01/25/12 in the 102 Waples Way cottage, it was determined that the facility failed to provide an HVAC system that functioned properly. Findings include:

1. The metal louvers of the floor vent of the

3201.6.6.1

- Contracted cleaning service provider was *terminated on 1/30/12*.
- Rooms 122, 124 & the hallway were thoroughly cleaned on 1/30/12 by State custodial staff. This area will continue to be cleaned by State staff. All floors were professionally cleaned 2/2, 2/3 &

Completed 2/6/12 & Ongoing

 The entire building was checked and thoroughly cleaned including professional cleaning of floors on 2/2, 2/3 &

Completed 2/6/12 & Ongoing

- Daily checks will be done by area staff, managers and the custodians' supervisors.
 - Completed 2/7/12 & Ongoing
- Office of Quality Management will complete quarterly environmental inspections.

To be completed by April 15, 2012 & Ongoing

3201.7.3.2

The louvers were tightened on 1/30/12.

Completed 1/30/12

- There are no other areas on campus with similar issues. Completed 1/30/12
- Area staff and managers will monitor daily. Completed 2/6/12 & Ongoing
- Maintenance will do routine checks.

Completed 1/30/12 & Ongoing

Funding has been secured for installation of new HVAC system.

To be completed by 7/1/13

 Office of Quality Management will complete quarterly environmental inspections.

To be completed by April 15, 2012 & Ongoing



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16 Del. C. Chapter 11 Subchapter III, § 1131

continuously collide. This noise would be area.

HVAC system in room 102A were loose.

The metal louvers made a clinking noise as the forced air caused them to

a nuisance to the residents in this sleeping

Definition.

(9) Neglect

(a) Lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals, and safety.

This requirement is not met as evidenced by:

Based on record reviews, staff interviews, and review of other documentation as indicated it was determined that for three (C11, C13, and C12) out of 13 clients sampled reviewed experienced neglect while residing in the facility. The facility neglected to thoroughly assess C11's (was dependant on continuous oxygen therapy) respiratory status when he experienced a change in condition and neglected to provide nursing services in accordance with C11's needs. The facility neglected to conduct a thorough assessment of C13's respiratory status, neglected to notify the physician for appropriate interventions and failed to use all resources available to them including respiratory personnel. C12 had a change in condition as evidenced by low blood pressure, rapid heart rate, and decreasing blood oxygen saturation and the facility neglected to closely monitor and reassess C12's condition that resulted in C12 being admitted to the hospital for acute hypoxemic respiratory failure secondary to aspiration pneumonia.

W 331

Appropriate corrective actions were completed with all nurses involved in the referenced incidents.

Completed 2/17/12

A memo was sent on 2/6/12, to all nursing staff outlining the expectations for completing thorough physical assessments and prompt notification of the medical team. Exhibit C

Completed 2/6/12

A sweep of records for residents with recent significant medical issues was completed using the attached COR Nursing/Medical Review form. Exhibit D

Completed 2/21/12

- The findings from these reviews will be reviewed by the Director of Nursing and appropriate corrective actions will be To be completed by 3/9/12
- An in-service for nursing staff on Physical Assessment will be presented by the nurse practitioners the weeks of March 5 and 12, 2012.

To be completed by 3/16/12

The Nursing Documentation Procedure will be revised to include the routine ongoing monitoring of nursing documentation by the nursing supervisors.

To be completed by 3/9/12 & Ongoing



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Findings include:

1. C11 had diagnoses that included profound mental retardation, seizures, microencephaly, severe dysphagia (received feedings via gastrostomy tube/G-tube), severe asthma, progressive pulmonary disease with fibrosis, was receiving oxygen at 2 liters per minute and morphine therapy for chronic cough and dyspnea. C11 had a current "Do not resuscitate" order. C11's nursing care plan stated: Observe for and document signs and symptoms of ineffective breathing such as shortness of breath, nasal flaring, apnea etc.

Review of C11's routine progress note by the attending physician dated 4/11/11 documented blood pressure (B/P) of 107/72, heart rate (HR) of 88 per minute, respiratory rate (RR) of 18 per minute, and pulse oximetry (monitors oxygen saturation) of 92% on 2 liter of oxygen.

The CNA (certified nursing assistant) note dated 4/16/11 and timed 4 PM documented that C11 "yelled more today than normal." At approximately 8:15 PM, the charge nurse documented C11's vital signs: temperature (T) 100.8 F axillary (AX), RR 36, HR 128, pulse oximetry 95 - 98% on 2 liters oxygen (no BP noted) and a respiratory assessment as follows: "rhonchi bilaterally, grunting breathing." Also documented was "Seizure activity witnessed by Respiratory (therapist) lasting 1 minute & 15 seconds." The nurse practitioner (NP) was notified and orders obtained. The verbal physician order read as follows:

1. Tylenol (medication) 6.5 ml.

W 331 continued

 The Physician's Generic Standing Orders and Medical Team Notification policy for medical team notification will be revised to include instructions for when a member of the medical team does not respond timely.

To be completed by 3/9/12

 The nurse supervisors will be trained on proper completion of the COR Nursing/Medical audit.

To be completed by 3/16/12

 The nurse supervisors will complete routine periodic COR Nursing/ Medical audits to ensure thorough documentation and prompt notification of the medical team has occurred.

To be completed by 4/1/12 & Ongoing

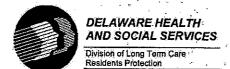
 These audits will be reviewed by the Director of Nursing for any deficient practices and appropriate actions will be taken with the nurses involved.

To be completed by 4/1/12 & Ongoing

 Designation has been made for a nursing educator at Stockley Center.

Completed 2/16/12 & Ongoing

| Rrovider's Signature | w. f | ч | 20 | Date | |
|----------------------|------|---|----|----------|--|



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(milliliter)/650 mg. (milligram) via G-Tube prn (as needed) @ (at) 2AM, 12 noon, 4PM for temp. >99.9 AX x (times) 48 hrs.(hours)

- 2. Vital signs q (every) 4 hrs. x 48 hrs.
- 3. Sputum culture 4/17/11 AM
- 4. CXR (chest X-ray) 4/17/11
- 5. Avelox (antibiotic) 400 mg. via G-Tube q day x 10 days after sputum culture obtained."

The nursing note dated 4/16/11 and timed 9:55 PM documented C11's vital signs: T 97.7 AX, pulse oximetry 95% on 2 liters oxygen, HR 122, RR 30, and B/P 106/73, A seizure lasting 15 seconds and grunting respirations were also documented. The medication administration record for April 2011 noted C11's routine bedtime medication APAP 650 mg. (which was a generic form of Tylenol) was administered. C11 had not voided that shift and the nurse reported these findings to the charge nurse and neglected to notify the NP who was on call. The night shift nursing note dated 4/17/11 documented vital signs from 12 AM to 5 AM. The RR was 22 to 28 but there was no documentation of C11's respiratory status (or oxygen level) other than the pulse oximetry reading of 93% and HR of 122 at 12 AM. The nurse documented that C11 voided a small amount and supervisor was notified.

The nursing note date 4/17/11 and timed 7:17AM documented full vital signs of HR of 116 and RR of 28, while C11 was on 2 liters of oxygen, and a lung (some rhonchi, no wheezing) and gastrointestinal (abdomen slightly firm from distention) assessments. At 9:40 AM (Over 13 hours since the order was written) sputum culture, CXR and Avelox administration

W 331 continued

 The Executive Director has established a more thorough internal death review process.

Exhibit E

Completed 2/16/12 & Ongoing

 The Office of Quality Management will be asked by the Executive Director to complete surveys to ensure implementation of any recommendations/changes/corrective measures for all deaths.

After the Next Death & Ongoing

 The Facility Records Committee has been revised to the "Facility Peer Review Committee" that will have the responsibility to ensure compliance of individual records with applicable regulatory statutes and accrediting/ licensing standards across all settings.

Exhibit F

Completed 2/16/12 & Ongoing

• The Office of Quality Management will be asked by the Executive Director to complete quarterly random surveys to ensure implementation of any recommendations/ changes/ corrective measures for all deaths.

To be completed by 4/30/12 & Ongoing



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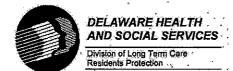
were completed (no respiratory assessment noted).

The nursing note at 11:20 AM documented that C11 was found at approximately 10:55 AM grunting at a rate of 60 breaths/min., pulse oximetry 81% (critical low value) on 2 liters of oxygen which only increased to. 84% when liters increased to 4 liters; skin was cool and clammy with HR of 115 and BP of 114/65. Respiratory therapy was notified of C11's distress and unable to auscultate breath sounds. Oxygen mask at 10 liters was applied which increased the pulse oximeter to 92% (normal standard dictated in policy). The nursing supervisor was notified and C11 was transported to the (name of hospital) where he was admitted for treatment. The treatment was discontinued and C11 was given IV (intravenous) Morphine and later expired at 7:30 PM. Cause of death documented as acute respiratory failure and pneumonia.

Review of the facility's nursing policy and procedure titled "Nursing Documentation" stated: "IV. Situation Requiring Documentation:

-Change in individual's health status (illness or injury)

The facility neglected to perform a respiratory assessment from 8:15 PM to 6:30 the following AM on a client who was having respiratory complications. The radiology service was available to perform



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CXR after-hours and nurses could have obtained the sputum cultures yet diagnostic services were ordered for the AM. The facility neglected to provide necessary services in a timely manner for C11 who was in respiratory distress.

An interview with respiratory therapist, E9 on 1/26/12 at approximately 2:30 PM revealed that the therapists worked 10-12 hrs, daily and the nurses are to perform all respiratory care and treatment in their absence. (They also document on nasal cannula oxygen dependent clients by exception per facility policy and report any abnormal findings to the nurse on duty.) These statements were confirmed by Qualified Mental Retardation Professional (E10) at 2:45 PM.

An interview with the medical director E6 on 1/27/12 at approximately 11:30 AM confirmed the delay in service of diagnostic services including CXR and sputum culture which were not done until the AM, thus, antibiotic (that is in their stock pharmacy) treatment was not initiated. The facility neglected to complete thorough assessments for C11. The facility also neglected to notify the NP when C11's health status was continually declining and failed to contact the medical director when orders were written to be completed over 12 hours later. Findings were reviewed with Director of Nursing, E3 on 1/27/12 at 12 PM who also confirmed the above findings.

2. C13 was admitted to the facility with diagnoses that included profound mental retardation, hypothyroidism, osteoporosis, severe kyphoscoliosis, thrombocytopenia, bipolar disease, blindness, dysphagia, colostomy and jejunostomy tube.



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The November 2011 physician order for C13 documented an order for "Duoneb 2.5/0.5 mg, via nebulizer every 4 hours as needed for shortness of breath/wheezing."

Review of C13's "Interdisciplinary/Progress Notes (IDCP Notes)" dated 11/27/11 and fimed 6 AM written by the 11-7. CNA stated C13 was awake on and off through the night with some coughing. The 11-7 nurse documented in the IDCP Notes that at 6 AM, C13's vital signs were T of 97.6 F axillary, B/P 118/68, HR 88, RR 20 and her pulse oximetry of 95% on room air (RA). The nurse continued to document that C13 had a deep, non-productive cough that was noted throughout the night.

The facility's nursing procedure for "Assessing Respirations" stated to determine the rate and quality of a resident's respiration rate the nurse assess the depth of the respirations by observing . movement of the chest. Describe as normal, deep or shallow. The nurse should auscultate and percussion may be needed to assess abnormal lung sounds. Document and report pertinent assessment data. C13's record lacked evidence that her lungs were auscultated or an assessment was done of the depth of the respirations even though she was documented to have deep non-productive cough. The facility neglected to do a thorough respiratory assessment on C13.

On 11/27/11 at 11:30 AM, the 7-3 nurse documented that she walked into C13's room at 11:13 AM. She was sitting in her wheelchair. Hands were cold to touch, mouth cyanotic. There was no pulse. Nurse supervisor was notified and C13.



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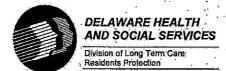
was pronounced dead. The nursing supervisor documented that the physician and the guardian were notified. The record review lacked evidence indicating that the 7-3 nurse assessed C13 who had a change in condition by having a deep non-productive cough on the 11-7 shift before C13 was found deceased. The facility neglected to do a thorough assessment on the 11-7 shift and failed to do any assessment on the 7-3 shift until after C13 was found deceased.

Review of C13's death certificate revealed the cause of death was sudden cardiorespiratory death, tracheobronchial plugging of mucus, debilitating condition, old age and multiple medical conditions, and dysphagia. The manner of death was documented as being natural.

On 1/26/12 at 12:05 PM, an interview with E3, Director of Nursing revealed that the 11-7 nurse should have completed a thorough assessment. The 7-3 nurse should have assessed C13 when she came in. The staff could have notified the Respiratory staff if they had a respiratory/coughing concern.

On 1/27/12 at 8:50 AM, the surveyor met with the Administrator E1, the Medical Director E6, and E3. The concerns surrounding the care of C13 identified were presented to this team. All the concerns were confirmed.

On 1/27/12 at 11:10 AM interview with E7, Respiratory Therapist revealed that if anyone from his department was notified of any respiratory problem or coughing problem, they would have documented their assessment in the IDCP Notes or on the Treatment Assessment Record.



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Review of these two records failed to have documentation that the respiratory personnel were notified of C13's non-productive deep cough or that a staff member administered a nebulizer treatment for C13. The facility neglected to use all resources available to them to ensure C13 received the care necessary for her respiratory condition.

3. C12 was admitted to the facility with diagnoses including mental retardation severe, Tourette's Syndrome, osteoarthritis, hypertension, histories of anemia and iron deficiency, chronic constipation.

Review of C12's Nursing Quarterly Visual Review dated 2/20/11 documented B/P 121/80, HR 72, RR 16, and pulse oximetry of 96% on room air (RA).

Review of the "IDCP Notes" dated 3/15/12 timed 7:24 AM documented by E4 (Registered Nurse) that C12 was complaining of nausea and vital signs included B/P of 86/64, HR of 102, RR of 24 and pulse oximetry of 90-92%. In addition, C12 vomited small amount of frothy white/clear emesis and abdominal assessment revealed hypoactive bowel sounds with tenderness noted on palpation of right lower quadrant and to be seen by M.D.

Subsequent IDCP Noted dated 3/15 and timed 9 AM documented that "NP (Nurse Practitioner/E5) called unit and E5 notified of C12's status. Emesis X2."

Subsequent IDCP Noted dated 3/15/11 and timed 12:20 PM documented that at 10:40 AM, C12's HR was 120, RR24, pulse oximetry of 84-88%. Oxygen tank



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obtained with nasal cannula. Resp. (Respiratory) and NP (E5) contacted. Lungs bilaterally with rhonol, color poor, and using accessory muscles. Respiratory distress. Code called. C12 sent by ambulance to the hospital.

Although C12 had an abnormal vital signs, as evidenced by low blood pressure, rapid heart rate, and decreasing oxygen saturation, record review lacked evidence that C12's health condition was closely monitored or reassessed from the initial assessment at 7:24 AM until 10:40 AM, when C12 was found in respiratory distress.

Review of the admission history and physical dated 3/15/11 revealed that upon arrival, C12's B/P was 77/53, HR of 124, RR of 59, and pulse oximetry was between 78-80%; "Reason for Admission: acute hypoxemic respiratory failure secondary to aspiration pneumonia."

An interview with E4 (Registered Nurse) on 1/26/12 at approximately 10 AM revealed she checked on C12 after the initial assessment at 7:24 AM, however, E4 could not recall what reassessment information was gathered.

An interview with E5 on 1/30/12 at approximately 2:35 PM revealed that she does not recall whether she was paged three times on 3/15/11 from approximately 7:24 AM to 9 AM. In addition, E5 related that if she was informed of the above significant change in condition, E5 would have sent the client earlier to the hospital since she would have known that the client's condition was quickly deteriorating.

An interview with E3 on 1/27/12 at



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DATE SURVEY COMPLETED: January 27, 2012

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
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| | approximately 1 PM confirmed that due to C12's change in health condition, she would have expected that C12's health condition would have been closely monitored and reassessed. | |
| 3 | Findings reviewed with E1, E2 (Director of Residential Services), and E3 on 1/27/12 at approximately 1:30 PM. | |
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